Supreme Court, U.S.
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No. 09-1416

IN THE
Supreme Court of the United States

CHARLES D. GIANETTI,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD
OF CONNECTICUT, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED FOR REVIEW

1. Did the Court of Appeals err in affirming the District Court's decision to dismiss Counts Five and Six of the plaintiff's complaint, alleging fraud and misrepresentation and violation of the Connecticut Unfair Trade Practices Act, Conn. Gen. Stat. § 42-110a, *et seq.*, on the ground that such claims are preempted by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.*?

2. Did the Court of Appeals err in determining that the District Court did not abuse its discretion in not allowing the plaintiff to amend his complaint?

STATEMENT PURSUANT TO RULE 29.6

In compliance with Supreme Court Rule 29.6, defendants-respondents Blue Cross Blue Shield of Connecticut, Inc., Anthem Health Plans, Inc., and Anthem Insurance Companies make the following disclosure:

Anthem Health Plans Inc. d/b/a Anthem Blue Cross and Blue Shield is a wholly owned subsidiary of ATH Holding Company, LLC, which in turn is a wholly owned subsidiary of WellPoint, Inc.

Anthem Insurance Companies is a wholly owned subsidiary of WellPoint, Inc.

The entity Blue Cross Blue Shield of Connecticut, Inc., is no longer in existence.

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STATEMENT OF THE CASE

The present action arises from reconstructive plastic surgery that the plaintiff, Charles D. Gianetti, M.D., allegedly performed on defendant Samaris Rose on March 10, 1999. Ms. Rose, who was a minor at the time of this surgery, is the daughter of defendant Cynthia Bellamy. (*See* Complaint, ¶ 3.) As of the date of the alleged surgery, Ms. Rose and Ms. Bellamy were both insured under the BlueCare Plus Point of Service Subscriber Agreement issued by the defendants-respondents, Blue Cross Blue Shield of Connecticut, Inc., Anthem Health Plans, Inc., and Anthem Insurance Companies (collectively referred to herein as "Anthem") to Caresys, Inc. The Caresys, Inc. health benefit plan under which Ms. Rose and Ms. Bellamy were insured ("the Caresys Plan") is an employer sponsored health benefit plan and is governed by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* ("ERISA").

By way of Complaint dated September 17, 2007, the plaintiff alleges that he sent a statement of charges for Ms. Rose's 1999 surgery, in the amount of $7,695.00, along with an assignment of benefits, to Anthem as Ms. Rose's insurer under an ERISA plan. (*See* Complaint, ¶ 6.) The plaintiff was not a participating provider under the Caresys Plan. The plaintiff allegedly entered into an agreement with Ms. Rose and Ms. Bellamy whereby they agreed to assume responsibility for payment of all fees regardless of insurance. (*See* Complaint, ¶ 15.) The Complaint alleges that, in October of 2000, the plaintiff received a payment from Anthem of $3,019.50 for the services rendered to

Ms. Rose. (*See* Complaint, ¶ 7.) The Complaint further alleges that a portion of the plaintiff's claim for reimbursement was denied by Anthem as not covered. (*See* Complaint, ¶ 9.) The plaintiff alleges that Anthem subsequently denied his requests for payment of the balance of his charge. (*See* Complaint, ¶ 11.) The plaintiff also alleges various errors by Anthem in the handling and administration of his claim. Namely, the plaintiff claims that, on June 25, 2001, his request for a review of the charges was denied as untimely. (*See* Complaint, ¶ 29.) The plaintiff further claims that Anthem has not properly accounted for payments made to its members and that he was informed by an Anthem representative that Ms. Rose's records had been purged even though Anthem subsequently submitted a listing of the claim's disposition. (*See* Complaint, ¶¶ 24-31.) Defendants Bellamy and Rose have allegedly denied receiving any payments from Anthem and have refused to pay the balance allegedly due to the plaintiff. (*See* Complaint, ¶¶ 16 and 27.)

On the basis of these allegations, the plaintiff originally brought this action in state court asserting claims of breach of contract, quantum meruit, unjust enrichment, fraud and misrepresentation, and violation of the Connecticut Unfair Trade Practices Act, Conn. Gen. Stat. § 42-110a, *et seq.* ("CUTPA"). Anthem removed the action to the United States District Court for the District of Connecticut on the ground that it was completely preempted by ERISA. On January 24, 2008, Anthem moved to dismiss the claims brought against it, pursuant to Fed. R. Civ. P. 12(b)(6), on the ground that such claims were preempted by ERISA. On May 2, 2008, the court, Dorsey, J., granted the motion to dismiss,

holding that all claims brought against Anthem were preempted by ERISA.[1] (*See* District Court's Ruling on Motion to Dismiss, 2008 WL 1994895 (D.Conn. 2008).) The District Court also, in its discretion, chose not to grant the plaintiff leave to amend his complaint.

The plaintiff thereafter filed an appeal of this decision with the Second Circuit Court of Appeals, seeking to overturn the District Court's ruling as to Counts Five and Six of the Complaint against Anthem.[2] The Court of Appeals affirmed the District Court's decision to dismiss the plaintiff's claims and additionally determined that the District Court did not abuse its discretion in not granting plaintiff leave to amend his complaint. (*See* Summary Order of Court of Appeals, 351 Fed. Appx. 520 (2d Cir. 2009).)

REASONS FOR DENYING THE PETITION

A. PURSUANT TO SUPREME COURT RULE 10, REVIEW OF THE PRESENT MATTER IS NOT WARRANTED.

It must be noted at the outset that the plaintiff's Petition does not implicate any of the considerations set forth in Supreme Court Rule 10, so as to warrant review on a writ of certiorari. The plaintiff has not identified any conflicting decisions by another United States court

[1] The District Court's ruling also dismisses all claims brought against defendants Ms. Rose and Ms. Bellamy.

[2] The plaintiff did not contest the District Court's decision dismissing Counts One, Three and Four against Anthem.

of appeals or a state court of last resort. Indeed, as discussed below, the underlying rulings in this case are entirely consistent with well established federal law regarding ERISA. This case also does not involve a departure from the accepted course of judicial proceedings, as the District Court acted entirely within its discretion in not granting the plaintiff permission to amend his complaint.

Finally, the issues involved in the present case do not implicate any important questions of federal law that need to be settled by this Court, nor does this case involve a decision on an important federal question that is in conflict with a decision of this Court. Rather, although the present dispute falls under ERISA, it essentially amounts to a dispute over fees for medical services rendered. That is not an issue on which this Court should waste its limited resources.

B. THE COURT OF APPEALS PROPERLY AFFIRMED THE DISTRICT COURT'S DECISION TO DISMISS THE PLAINTIFF'S CLAIMS OF FRAUD AND MISREPRESENTATION AND VIOLATION OF CUTPA ON THE BASIS OF ERISA PREEMPTION.

As an initial matter, it must be noted that it is unclear, with regard to the claims against Anthem, exactly which rulings the plaintiff contests through his present Petition for Writ of Certiorari. The plaintiff presents, as a question for review:

> Has the Court of Appeals for the Second Circuit deprived the plaintiff-appellant of due

> process by failing to reverse the dismissal of the counts of the Complaint as to defendant Anthem Blue Cross and Blue Shield of Connecticut, Inc.?

(*See* Plaintiff's Petition for Writ of Certiorari, p. i). It would appear from this statement that the plaintiff is attempting to contest the District Court's decision to dismiss all counts directed against Anthem. However, the plaintiff's Petition contains no argument whatsoever as to whether his claims against Anthem were improperly dismissed on the basis of ERISA preemption. The plaintiff also states, at page 11 of his Petition, that he concedes "the claims against defendant Anthem . . . are governed by ERISA . . ." Thereafter, the plaintiff states that it is his concession that, "except for the fraud and misrepresentation and CUTPA counts, the claims against defendant Anthem are preempted by ERISA." (*See* Plaintiff's Petition for Writ of Certiorari, p. 13). Perhaps most importantly, in his appeal to the Second Circuit Court of Appeals, the plaintiff raised only the issue of the District Court's decision to dismiss Counts Five and Six of his Complaint, sounding in fraud and misrepresentation and violation of CUTPA. Therefore, if this Court is to give any consideration as to whether it will grant the plaintiff's Petition as to the issue of ERISA preemption, such consideration should be limited to Counts Five and Six of the plaintiff's Complaint. *See Singleton v. Wulff*, 428 U.S. 106, 120, 96 S.Ct. 2868, 2877 (1976) ("It is the general rule, of course, that a federal appellate court does not consider an issue not passed upon below.")

With regard to Counts Five and Six, review by this Court is not warranted as the Court of Appeals correctly upheld the District Court's determination that such claims against Anthem must be dismissed on the basis of ERISA preemption. When it enacted ERISA, it was the intention of Congress to create a comprehensive statutory scheme to regulate all employee benefit plans, including those that provide "through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits . . ." 29 U.S.C. § 1002(1). In order to ensure uniformity in the regulation of these employee benefit plans, Congress specifically provided that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144 (a). Noting the broad language of this preemption clause, this Court has held that ERISA replaces *all* state laws in the regulation of employee benefit plans. *See Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98-99 (1983). Accordingly, the phrase "relates to" any benefit plan is to be given its "broad common sense meaning." *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). *See also Empire Healthchoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 157 (2d Cir. 2005). Therefore, a state law "relates to" a benefit plan "if it has a connection with or reference to such a plan." *Shaw*, *supra*, 463 U.S. at 97. *See also Metropolitan Life Insurance Co. v. Bigelow*, 283 F.3d 436, 440 (2d Cir. 2002).

More recently, this Court has stated that "if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of

action is completely pre-empted by ERISA § 502(a)(1)(B)." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004) (finding claims "to rectify a wrongful denial of benefits promised under ERISA-regulated plans" which "d[id] not attempt to remedy any violation of a legal duty independent of ERISA" to be completely preempted by § 502 and removable to federal court). Thus, under *Davila*, the Court first must determine whether the plaintiff "at some point in time, could have brought his claim under ERISA § 502(a)(1)(B)" and if so, whether any "independent legal duty is implicated by [defendants'] actions," *Id.* at 210. Additionally, if the defendants' potential liability is derived from or dependent upon the existence and "administration of a ERISA-regulated benefit plans," then the state-law claims are not "entirely independent of the federally regulated contract itself," and are therefore preempted. *Id.* at 213.

Under this expansive construction of ERISA's preemption clause, it is clear that the present plaintiff's claims of fraud and misrepresentation and CUTPA violation are derived from Anthem's administration of a claim made under an ERISA benefit plan and the plaintiff's causes of action would not exist were it not for the existence of the ERISA plan. The plaintiff has no independent contract with Anthem. He was not a participating provider with Anthem. The plaintiff sought payment from Anthem, pursuant to an ERISA plan, as an assignee of his patient. As the plaintiff himself alleged, Anthem then made a reimbursement payment to the plaintiff under the ERISA plan. The conduct of which the plaintiff now complains is the manner in which Anthem administered his claim under the ERISA plan

recognized as reasons for its decision to not grant leave to amend that the plaintiff's claims against Anthem are likely barred by the statute of limitations, as well as the appearance of bad faith based on the plaintiff's history of litigation[4]. Therefore, the District Court did not abuse its discretion in refusing to allow the plaintiff to amend his complaint and its decision was properly affirmed by the Court of Appeals. No further review of this decision is warranted.

CONCLUSION

The District Court properly dismissed Counts Five and Six of the plaintiff's Complaint, and this decision was correctly affirmed by the Second Circuit Court of Appeals. The Court of Appeals also correctly determined that the District Court did not abuse its discretion in not allowing the plaintiff to amend his Complaint. The

(Cont'd)

lawsuit, setting forth his causes of action, and thereafter was able to file an objection to the defendant's Motion to Dismiss. The fact that he did not properly set forth any viable causes of action is not a deprivation of the plaintiff's due process rights.

[4] In this regard, it should be noted that the Connecticut Attorney General instituted an action against the present plaintiff, wherein it was alleged that although Dr. Gianetti was prohibited from collecting money from patients utilizing certain managed care plans, he "nevertheless engaged in 'balance billing' in violation of 42 U.S.C. 1320a-7a(a)(2) and 42 U.S.C. 1320 7b(d) and Connecticut General Statutes 53a-290 (Medicaid restrictions) and Connecticut General Statutes 42-110b(a) (Connecticut Unfair Trade Practices Act)." *State v Gianetti*, No. CV 04 000594, 38 Conn. L. Rptr. 524, 2005 WL 407638, at *1 (Conn. Super. Ct. Jan. 11, 2005) (Dewey, J.).

decisions of the District Court and the Court of Appeals in this case are not in conflict with any decision of this Court, or any decision of another United States court of appeals or a state court of last resort. The issues involved in the present case also do not implicate any important questions of federal law that need to be settled by this Court. Finally, this case also does not involve a departure from the accepted course of judicial proceedings, as the District Court acted entirely within its discretion.

Therefore, the plaintiff's Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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